

MONTANA LEGISLATIVE HISTORY

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Chapter 527 19 95

Bill H 533 S _____ Original bill & history X C

H. Committee on Select Health Care

Hearing Date(s) Feb 14 ✓ C

Feb 16 ✓ C

_____ ✓ C

_____ ✓ C

Date Out Feb 17 ✓ C

S. Committee on Joint Select Health Care

Hearing Date(s) Mar 09 ✓ C

Mar 16 ✓ C

_____ ✓ C

_____ ✓ C

Mar 17 ✓ C

Did this bill originate in an interim committee? Yes No

Committee _____

Report _____

READING SINCE THIS BILL, WHILE IN THE HOUSE, ALREADY HAD BEEN REPORTED OUT OF THIS COMMITTEE.

3/25	2ND READING CONCUR MOTION FAILED	14	28
3/25	2ND READING INDEFINITELY POSTPONED	27	16
3/27	RECONSIDERED PREVIOUS ACTION AND PLACED ON 2ND READING ON 71ST DAY	40	8
3/29	2ND READING CONCURRED	33	10
3/30	3RD READING CONCURRED	41	9
	RETURNED TO HOUSE		
4/03	SIGNED BY SPEAKER		
4/04	SIGNED BY PRESIDENT		
4/05	TRANSMITTED TO GOVERNOR		
4/10	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 349		
	EFFECTIVE DATE: 10/01/95		

HB 532 INTRODUCED BY TASH, ET AL.
REDEFINE "MENTALLY ILL" FOR PURPOSES OF THE MENTAL ILLNESS TREATMENT LAW

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO HUMAN SERVICES & AGING		
2/15	HEARING		
2/15	TABLED IN COMMITTEE		
2/23	MISSED TRANSMITTAL DEADLINE DIED IN COMMITTEE		

HB 533 INTRODUCED BY ARNOTT, ET AL.
PROVIDE FOR PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO HEALTH CARE SELECT		
2/14	HEARING		
2/17	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/20	2ND READING PASSED	98	1
2/21	3RD READING PASSED	100	0
	TRANSMITTED TO SENATE		
2/27	FIRST READING		
2/27	REFERRED TO BUSINESS & INDUSTRY		
3/06	REFERRED TO JOINT HEALTH CARE SELECT		
3/09	HEARING		
3/18	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/21	FISCAL NOTE REQUESTED		
3/21	2ND READING CONCURRED AS AMENDED	50	0
3/22	3RD READING CONCURRED	49	0
	RETURNED TO HOUSE WITH AMENDMENTS		
3/23	FISCAL NOTE RECEIVED		
4/03	2ND READING AMENDMENTS CONCURRED	98	1
4/04	3RD READING AMENDMENTS CONCURRED	98	0
4/06	SIGNED BY SPEAKER		
4/07	SIGNED BY PRESIDENT		
4/11	TRANSMITTED TO GOVERNOR		
	RETURNED TO HOUSE WITH GOVERNOR'S PROPOSED AMENDMENTS		
4/12	2ND READING GOVERNOR'S AMENDMENTS CONCURRED	97	3

4/13	3RD READING GOVERNOR'S AMENDMENTS CONCURRED	98	1
	SENATE		
4/13	2ND READING GOVERNOR'S AMENDMENTS CONCURRED	50	0
4/13	3RD READING GOVERNOR'S AMENDMENTS CONCURRED	50	0
4/18	SIGNED BY SPEAKER		
4/18	SIGNED BY PRESIDENT		
4/18	TRANSMITTED TO GOVERNOR		
4/25	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 527		
	EFFECTIVE DATE: 01/01/96		

HB 534

INTRODUCED BY HARRINGTON, ET AL.

ALLOW CERTAIN UNDEVELOPED LAND OWNED BY A LOCAL ECONOMIC
DEVELOPMENT ORGANIZATION TO QUALIFY AS AN INDUSTRIAL PARK
FOR PROPERTY TAX PURPOSES

2/02	HEARING		
2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO TAXATION		
2/13	FISCAL NOTE REQUESTED		
2/15	FISCAL NOTE RECEIVED		
2/15	FISCAL NOTE PRINTED		
3/02	HEARING		
3/02	COMMITTEE REPORT—BILL PASSED		
3/04	2ND READING PASSED	89	10
3/06	3RD READING PASSED	86	13
	TRANSMITTED TO SENATE		
3/07	FIRST READING		
3/07	REFERRED TO TAXATION		
3/15	HEARING		
3/16	COMMITTEE REPORT—BILL CONCURRED		
3/24	2ND READING CONCURRED	49	0
3/25	3RD READING CONCURRED	48	0
	RETURNED TO HOUSE		
3/27	SIGNED BY SPEAKER		
3/28	SIGNED BY PRESIDENT		
3/28	TRANSMITTED TO GOVERNOR		
3/29	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 277		
	EFFECTIVE DATE: 10/01/95		

HB 535

INTRODUCED BY HARRINGTON, ET AL.

ALLOW INCOME TAX OR CORPORATE LICENSE TAX CREDIT FOR
PRESERVATION OF HISTORIC BUILDINGS

2/11	INTRODUCED		
2/11	FIRST READING		
2/11	REFERRED TO TAXATION		
2/13	FISCAL NOTE REQUESTED		
2/17	FISCAL NOTE RECEIVED		
2/22	FISCAL NOTE PRINTED		
3/02	HEARING		
3/16	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/18	2ND READING DO PASS MOTION FAILED	45	52

1 *Wells Brainard* House BILL NO. *533* *Leander X Henry*
 2 INTRODUCED BY *Annette Barnett* *Mills McKee* *GRINDE*
 3 *Wiseman* *Green* *Denny* *Sam Nelson* *Hilford* *Forbes*
 4 *Ruox* *Curtiss* *ORR* *Storall* *Hayne*
 5 A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE
 6 PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS
 7 APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO
 8 BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; AND AMENDING SECTION
 9 33-22-101, MCA." *Smith* *DeBrugger* *Leander* *Forbes*
 10 *Feiland* *Clark* *Jayla* *Mercer* *Simpkins* *Bellows* *McE*
 11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Definitions. As used in [section 2], unless the context indicates otherwise, the following definitions apply:

(1) "Health care insurer" means a health care insurer as defined in 33-22-125.

(2) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued or delivered for issue to an individual or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals.

(b) Individual health benefit plan does not include a self-insured group health plan; a self-insured multiemployer group health plan; a group conversion plan; an insured group health plan; accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

(3) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the standard health benefit plan referred to in 33-22-1811 and 33-22-1812 if the insurance or plan has been in effect for a period of at least 1 year; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society if the plan has been in

effect for a period of at least 1 year.

NEW SECTION. Section 2. Portability of insurance required. A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services, if the qualifying previous coverage was continuous to a date not more than 30 days prior to the effective date of new coverage.

NEW SECTION. Section 3. Premium increases to be distributed proportionately. (1) A health care insurer may increase the health benefit plan charges for a group or individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately by premium amount to all the policy, certificate, and contract holders of that insurer in the state.

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract.

(ii) Health benefit plan does not include:

(A) accident only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(B) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(C) automobile medical payment insurance.

(b) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

Section 4. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, [section 3], 33-22-125, 33-22-130 through 33-22-132, and

1 33-22-304, do not apply to or affect:

2 (1) any policy of liability or workers' compensation insurance with or without supplementary
3 expense coverage;

4 (2) any group or blanket policy;

5 (3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only
6 those provisions relating to disability insurance as:

7 (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or
8 accidental means; or

9 (b) operate to safeguard contracts against lapse or to give a special surrender value or special
10 benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled,
11 as defined by the contract or supplemental contract;

12 (4) reinsurance."

13
14 **NEW SECTION.** Section 5. Codification instruction. (1) [Sections 1 and 2] are intended to be
15 codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to
16 [sections 1 and 2].

17 (2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the
18 provisions of Title 33, chapter 22, part 1, apply to [section 3].

19 -END-

CHAIRMAN--SCOTT ORR

SECRETARY-VIVIAN REEVES

NORMAL SCHEDULE => SITE: ROOM 437

DAYS: T,TH

TIME: 3:00 P.M.

HOUSE SELECT COMMITTEE ON HEALTH CARE

- BILL NO-- REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE - REREFERRED - DATE READ

HB0078	COBB, JOHN	1/03	1/19	HEALTH CARE AUTHORITY TO PUBLISH REPORTS ON HEALTH CARE FEES	NONE	VOTE:	
HB0085	RANEY, BOB	1/14	1/19	ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR ACTUAL AMOUNT OF MEDICAL EXPENSES	NONE	VOTE:	
HB0155	SMITH, LIZ	1/12	1/17	REPEAL SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT	TABLED ON 2/16	VOTE: 11-0	
HB0202	NELSON, THOMAS	1/14	NONE	ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR 1/2 MEDICAL INSURANCE PREMIUMS	NONE	VOTE:	TAXATION
HB0202	NELSON, THOMAS	1/30	2/02	ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR 1/2 MEDICAL INSURANCE PREMIUMS	NONE	VOTE:	
HB0405	NELSON, THOMAS	2/02	2/07	ALLOW VOLUNTARY PURCHASING POOLS, REVISE ASSOCIATIONS FOR GROUP DISABILITY	PASS AS AMENDED 2/16	VOTE: 11-0	2/17
HB0446	ORR, SCOTT	2/06	2/09	REVISE PREEXISTING CONDITION LAW	PASS AS AMENDED 2/16	VOTE: 9-2	2/17
HB0466	NELSON, THOMAS	2/08	2/14	AMEND SMALL EMPLOYER HEALTH CARE AVAILABILITY ACT	PASS AS AMENDED 2/16	VOTE: 6-5	2/18
HB0511	JOHNSON, ROYAL	2/10	2/14	CREATE HEALTH CARE ADVISORY COUNCIL; REPEAL HEALTH CARE AUTHORITY	PASS AS AMENDED 2/16	VOTE: 11-0	2/17
HB0531	ORR, SCOTT	2/11	2/14	PROVIDE FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH CARE SERVICES	NONE	VOTE:	
HB0533	ARNOTT, PEGGY	2/11	2/14	PORTABILITY OF INSURANCE AND PREMIUM INCREASE DISTRIBUTION	PASS AS AMENDED 2/16	VOTE: 11-0	2/17

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION**

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By CHAIRMAN SCOTT ORR, on February 14, 1995, at
3:00 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

Members Excused:

Rep. Betty Lou Kasten (R)

Members Absent:

None

Staff Present: David Niss, Legislative Council
Susan Fox, Legislative Council
Vivian Reeves, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Secretary wrongly stated the hearing date as January 14. The date of the hearing is February 14, 1995.

Ian Marquand, Montana TV Network, Room 2, State Capital, Helena, Montana filmed the hearing for news coverage only.

Committee Business Summary:

Hearing: HB 548, HB 531, HB 466, HB 533, HB 511
Executive Action: None

Mr. Akey said the standard plan and the basic plan are the two plans that a small employer carrier is required to guarantee issue. He stated that a carrier may offer other plans on the marketplace which are not guaranteed issue plans. Mr. Akey clarified that the intent behind the standard plan and the basic plan in the Small Employer Health Availability Act was to offer a range of guaranteed issue products on the marketplace. He added, if a carrier chooses to offer a plan that's more benefit rich than the standard plan then that would not be a guaranteed product, that would be a product that could be fully underwritten.

Closing by Sponsor:

REP. NELSON said, "It's been a good hearing, and a long hearing." He referred to Mr. Grogan's amendment "about opening up the window so that they can come back in." EXHIBIT 30 He said the issue of fairness is important and stated, "If we don't do that we become punitive," and that would not be good government.

REP. NELSON disagreed with Mr. Randash's statement, fourth paragraph and said "38.4% of employers pay some portion of the health insurance premium. He asked, "38.4% in relationship to what?" EXHIBIT 33 He stated that with group insurance, insurance companies will not issue a group policy unless the employer participates in paying a portion of the premium which is generally 75% of the employee's premium. He indicated that the employee would pay the rest. He stated that REP. L. SMITH'S comment on part-time employees is well taken. As he recalled, the current definition of a full-time employee is an employee working 30 hours. He indicated that HB 466, would amend the definition to read the employer can determine what those numbers of hours can be when he purchases the plan and he can set that anywhere between 20 and 40 hours. He indicated that this would stop the practice of employing two part-time employees to fill one job.

HEARING ON 533

Opening Statement by Sponsor:

REP. PEGGY ARNOTT, House District 20, Billings, Montana, stated HB 533 is an act relating to the health benefits plan providing for portability of health benefits plans by requiring insurers to waive certain time periods acceptable to preexisting conditions and requiring certain increases in charges to be distributed proportionately among all plans of an insurer. She indicated HB 533 came as a response to the heightened awareness of health care concerns; indicating that it would be irresponsible to do nothing. She said, this bill is the heart of response to health care concerns. She indicated that New Section 1 includes the definition of a health care insurer, what an individual health

care benefit plan is, and explains that this bill does not apply to small group or large group coverage. Previous coverage is defined in subsection 3. Portability is referred to in New Section 2. She explained that New Section 2 states that once an individual has satisfied a waiting period for qualifying for insurance, then after that have maintained coverage, they do not have to satisfy this waiting period again. New Section 3 states that insurers can raise premiums based on age, but other increases such as extremely high medical costs cannot be placed solely on the individual. The cost must be distributed proportionately throughout the contract holders. This is a basic premise of insurance; to spread the cost out evenly.

Proponents' Testimony:

Tom Hopgood spoke in support of HB 533 with some minor changes which will be explained by Tanya Ask.

Tanya Ask, Blue Cross/Blue Shield of Montana (BCBS), provided the Committee with proposed amendments. **EXHIBIT 34** She stated that the first amendment gives a new definition to "block of business," and this term will be used under the rating portion of this particular act. Amendment 2 would clarify that "health care insurer" means "disability insurer, health service corporation, or health maintenance organization." Item 3 addressed a question under small group reform and in other situations concern portability of coverage. Amendment 3 deleted the phrase "standard health benefit plan" because it was "applicable to the small group reform portion of insurance law." She reminded the Committee that these particular reform provisions will apply to individual insurance. On page 2, amendment 5, the premium distribution which **REP. ARNOTT** is concerned about is that an individual's claims experience within the individual marketplace, that it not adversely affect that individual's rates.

Ms. Ask stated that the only thing that would affect the individual's rates is change in age and overall utilization within that block of business. Premium distribution would be spread across the entire block of business; it would be spread proportionately across everybody who has that particular contract type in Montana. She stated that the purpose of insurance is to spread risk. On page 3, New Section 5 applies to applicability. The purpose is to ensure the phase in. The effective date would be January 1, 1996, and this particular requirement of portability would apply to all contracts entered into or renewed on or after January 1, 1996, to allow a phase in, to allow those costs to be treated proportionately, to also allow the phase in of that distribution of cost impact.

Susan Good, representing Heal Montana, spoke in support of HB 533 and the amendment proposed by Tanya Ask. She stated their gratitude to **REP. ARNOTT** for HB 533 for two reasons. Firstly, she stated the average person changes employment seven times, usually during his lifetime, and that portability prevents job-

lock. This is important in our mobile society. Secondly, she indicated that HB 533 would prevent extremely high premium rates at a time of catastrophic illness or injury. She said, "we believe that people will keep their insurance longer, and that will benefit us all."

Dean Randash, NAPA Auto Parts, spoke in support of HB 533.
EXHIBIT 35

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, the Montana Business and Health Alliance, requested that the wording be clarified in Section 2, indicating that maybe it could be construed as guaranteed issue for the individual.

Larry Akey, representing Montana Association of Life Underwriters, supported HB 533.

Mike Craig, representing the Health Care Authority, stated that the biggest concerns voiced by the public in 1994 was the portability and coverage issue. He stated that the HCA strongly endorsed the concept of dealing with this issue, and supported HB 533.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

REP. SIMPKINS indicated Section 2, and inquired about the wording "30 days prior to the effective date of new coverage. He questioned the 30 days, indicating that this would be an extremely short period of time to require no insurance.

Ms. Ask, BCBS, indicated that this had been discussed and stated that if an individual does have a preexisting condition, they are going to want assurance that they have full continuity of coverage without a break. "This does allow a small break in coverage and still allows them to carry their preexisting waiting period with them." However, if there is a medical problem, most people will either go with a COBRA continuation, a conversion, or if they are on individual coverage, they're going to pay their premiums until they have their next coverage in place because most people will not want a lapse in coverage. This does allow up to a 30-day lapse in coverage.

REP. SIMPKINS said, "We're assuming that they're coming off a plan that falls under COBRA?"

Ms. Ask, BCBS, answered, "It could, but it could also fall under something else that might fall under the other conversion provision." She stated that it allows portability from another conversion plan; if they are leaving a group situation and they

are buying individual; if they are moving from one individual to another; and that this particular provision allows other portability from Medicaid to an individual product.

REP. SIMPKINS inquired about an employee who quits for 6 months "to raise the kids," and if that person gets sick during that time, he sees "no attempt to say that the employee continue to pay the premium ... to maintain their own self-paid plan, "which would be similar to COBRA," and then they get hit in 30 days.

Ms. Ask stated that this addresses one market only; it is to allow portability into the individual marketplace, if the individual chooses to buy into that market. However, if an individual employee wants a COBRA continuation, they would have that option if it is available from their employer. If COBRA is not available from their employer, the individual would still have the ability to have an individual conversion if they are under an insured plan.

REP. SIMPKINS inquired about spreading the cost over an entire block of business.

Ms. Ask stated that this is not designed to be a comprehensive insurance or a comprehensive health care reform piece. It is only designed for the individual market. "There have been some companies in the past who have decided that they no longer want to write individual coverage totally in a state, or they no longer want to write a specific block of business, or they no longer want to write group insurance in the state," which has happened frequently. She indicated that several years ago, some carriers decided that they no longer wanted to write specific blocks of group insurance in a state, and they did leave their people high and dry. She indicated that this bill was not designed to "tell an insurance company that you must continue to do business in the state of Montana and you must continue to write certain types of policies." She indicated "that's still been left available to the marketplace to decide what's going to happen with that."

REP. SIMPKINS stated "portability doesn't mean too much when you refer to a conversion." He indicated that any conversion plans he knows of "were bad and expensive," stating that "it doesn't leave much of an option." He asked what the objection to change that to 60 days was, to at least give the person "time to breathe."

Ms. Ask stated that there is another bill being considered in the Senate which does have 60 days. "Part of the reason for 30 days is that there has been continuity throughout the code with other types of provisions which have to do with enrollment for infants." Newborn coverage is required under all insurance contracts in Montana. However, if that infant is going to continue to receive coverage, the infant must be enrolled in that particular contract, individual or group, within 30 days. She

said that 30 days is a standard. She commented that currently, there is absolutely no dictate by anybody that an insurance company must write in the individual marketplace. This is something that insurers who do operate in the individual marketplace are interested in doing for the overall good of health care reform.

REP. SIMPKINS stated that he wanted to understand the 30 days.

Ms. Ask said it says 30 days until the effective date of the new contract. She stated that most insurance agents, if they are enrolling somebody on the fifteenth, will in all likelihood, inform them that the coverage will be effective on the first of the next month.

Closing by Sponsor:

REP. ARNOTT thanked the Committee for a good hearing and stated that REP. SIMPKINS' questions are pertinent and certainly valid. She stated that HB 533 addresses portability and is a direct response to meet the need of those seeking insurance. As insurance stands today, the sick or injured face dramatically increased insurance premiums. In effect, they are priced out of the market; this bill addresses that very issue. She stated that when HB 533 becomes effective, insurers would not be able to selectively raise premiums on just one individual without problems. Instead, they would have to distribute the premium increases proportionately. This is cost-sharing. Insurers cannot change the rules after an illness has occurred. Another issue addressed by HB 533 is that if an individual has qualified for insurance and maintained coverage ... they do not have to go through another qualifying period. She stated that HB 533 is a response to the need for access to health care coverage for the individual, and answers some of the problems that have long faced health insurance. She urged a Do Pass motion on HB 533.

* * * * *

At this point in the meeting REP. NELSON made a motion to pass HB 533, if the Committee would like to take executive action.

CHAIRMAN ORR stated that the Committee could take executive action. He indicated some concern about the effective date and suggested that the Committee wait before taking executive action.

REP. SIMPKINS stated that he would make a motion to amend HB 533 to read "60 days."

CHAIRMAN ORR indicated that the Committee needed to work that out before taking executive action.

REP. NELSON said, "you can request the future executive date on an application for insurance 60 to 90 days."

REP. SIMPKINS said, "you can, but you're not guaranteed coverage until after that time."

REP. NELSON indicated that "it can go about 90 days."

CHAIRMAN ORR "overruled" and asked the Committee to wait until Thursday to take executive action.

HEARING ON 511

{Tape: 4; Side: 1.}

Opening Statement by Sponsor:

REP. ROYAL JOHNSON stated that HB 511 is an attempt to inform the people of Montana "that we know that the health care problems aren't going away." He indicated that the health care situation is not going to "rectify" itself. He stated that HB 511 will change the Health Care Authority to Health Care Council. New Section 1, page 1, line 19, the public does recognize a continued need for evaluation and analysis of Montana's health care system. Line 21, the emphasis is on affordability and access to the health care business. Line 22, to continue the public-private partnership in order to develop initiatives regarding health care reform to be presented to the 1997 legislature.

He stated, "The health care advisory council shall monitor and evaluate implementation of recent health care reform initiatives, including small group insurance, and all of the others you can read yourself in that particular paragraph." He stated that the health care advisory council would consist of ten members to be selected by May 1, 1995 because "it is imperative to keep this ball rolling on health care reform," and not to let this situation wait until October. He indicated that the ten Committee members will consist of four legislative members, five members representing a health care planning region to be selected by the governor, and one member representing the executive branch to be appointed by the governor.

Page 2, line 12 will be changed to read, "Legislators, and regional board who represent health care planning regions who want to serve on the health care advisory council shall apply to the president of the senate, speaker of the house, or governor, respectively, for a position on the council. He stated that the applicants should be knowledgeable about health care and be willing to commit the substantial time required to serve on the council. He stated that the previous Health Care Authority spent hours and hours of volunteer time on it as witnessed by the stack of books he indicated.

REP. JOHNSON commented on New Section 3 that "we want to appropriate enough money ... to make sure that they can have at least ten meetings," noting that they will have a little time off

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL

DATE 2-14-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten			✓
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		

House Bill 533
Amendments
Presented By Blue Cross and Blue Shield of Montana
February 14, 1995

Page 1

1. Line 13
Following: "."
Insert: " (1) "Block of business" means an individual disability insurance policy certificate or contract product type written and sold to a defined set of individuals by a health care insurer. All individuals covered by that type of policy or contract are considered within that block of business."
2. Line 14
Following: "means a"
Delete: "health care insurer as defined in 33-22-125."
Insert: "disability insurer, a health service corporation, or a health maintenance organization."
3. Line 27
Following: "provided under the"
Delete: "standard health benefit plan referred to in 33-22-1811 and 33-22-1812"
Insert: "plan being applied for"
4. Line 30
Following: "benefit society"
Insert: "that provides benefits similar to or exceeding the plan being applied for"

Page 2

5. Line 14
Following: "distributed proportionately"
Delete: "by premium amount to all the policy, certificate and contract holders of that insurer in the state."
Insert: "across the block of business."

Page 3

6. Line 13
Following: "."

Insert: **NEW SECTION. Section 5. Applicability.** (This act) applies to a policy, certificate, or contract of disability insurance and health service membership contract entered into or renewed on or after (the effective date of this act).

7. Line 14
Following "Section"
Delete "5"
Insert: "6"

8. Line 14
Following "1"
Delete " and 2"
Insert ", 2 and 5"

9. Line 18
Insert **NEW SECTION. Section 6. Effective Date.**
This act is effective January 1, 1996.

-END-

EXHIBIT 35
DATE Feb. 14, 1995
HB 533

HB-533 - Representative Peggy Arnott

February 14, 1995

Dean M. Randash - NAPA Auto Parts

I stand in support of HB-533. This bill address true "Insurance Reform" concerning "Portability" in a indiscriminate and just manor. It is very much needed and welcomed. Please pass HB-533.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEEBILL NO. HB 533DATE 2/14/95SPONSOR(S) Rep. Arnett

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tanya Ak	Blue Cross Blue Shield			☒
WARRY AKET	INT ASSOC OF LIFE UNDERWRITERS	533		☒
Ron Kynik	Self			
Paul Gorsuch	Project Heal	533		☒
Mike Schweitzer	Billings Anesthesiology	533		☒
Riley Johnson	NFIB	533		☒
Steve Turkiewicz	MADA Ins Trust	533		☒
Kent Merrius	Self	533		☒
Steve Ley	INT Soc. Anesthesiology	533		☒
Beverly Stone	Project Heal	533		
Don Uelman	Project Heal	533	☒	☒
Bill Olson	AARP	533		☒
Candice Oiffard	State Auditor's office	533		☒

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 533
DATE 2/14/95 SPONSOR(S) Rep. Arnett

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tom Haggard	HIAA	533		✓
Dore Allen	MMAP	533		✓
Ed Graham	MMAP	533		✓
Mike Craig	Health Care Auth	533		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

REP. SIMPKINS stated that there is a supremacy conflict and that a joint committee would be the only way to iron these out. He suggested that the bills be passed to the Senate and after the transmittal date, review the bills from the Senate and make recommendations.

REP. SIMON encouraged CHAIRMAN ORR to communicate to the President of the Senate that this Committee is interested in a discussion with representatives from the Senate to form a Joint Committee to discuss the health care bills.

REP. KASTEN stated that she had already spoken to everyone on her subcommittee list to see if any of the bills could be meshed.
EXHIBIT 5

REP. SIMON spoke in regard to the bills in his subcommittee.
EXHIBIT 5

REP. BARNHART said that she was not suggesting to hold everything up. Her suggestion was in regard to the two other bills which are similar.

REP. R. JOHNSON inquired if the Committee were still discussing the motion.

CHAIRMAN ORR said they were still on the Do Pass motion.

REP. SIMPKINS stated that HB 511 had an appropriation and the other two bills did not. He suggested passing this bill from this Committee to the Appropriations Committee, and then looking at the other two bills when they are passed from the Senate.

Vote: Question was called. Voice vote was taken. The motion carried unanimously, 11 to 0.

EXECUTIVE ACTION ON HB 533

Motion: REP. R. JOHNSON MOVED TO ADOPT AMENDMENT #1.

Discussion: Tanya Ask, Blue Cross/Blue Shield, explained the amendment. EXHIBIT 6

CHAIRMAN ORR requested that REP. R. JOHNSON inquired about the new effective date of January 1, 1996. Ms. Ask explained this was done to allow contracts to be modified on renewal. She said the sponsor, REP. PEGGY ARNOTT was in agreement with the amendment.

REP. SIMPKINS inquired about the wording: "block of business in the individual disability insurance policy certificate." Ms. Ask explained that not often in the individual market are a lot of individual options added on. However, dental/vision, and other options like that would be treated as one block of business because the basic contract remains the same.

REP. SIMPKINS inquired if a policy had a choice of deductibles, co-insurance and stop-loss would that all remain in the same block of business as long as the basic benefits remained the same.

Ms. Ask responded that in the individual marketplace there is usually not much variation of deductible on co-insurance, however, it would all remain within the block of business.

REP. J. JOHNSON inquired if portability of insurance and guaranteed issue are different or if they are one and the same. Ms. Ask stated that portability and guaranteed issue are two different terms. She explained the terms.

REP. J. JOHNSON asked if they could have portability without guaranteed issue in the same bill. Ms. Ask stated that HB 533 deals only with portability of the preexisting waiting period. However, theoretically, guaranteed issue could be included in the same bill.

REP. R. JOHNSON inquired if there was anyone opposed to these amendments.

REP. KASTEN inquired about the difference between "health care insurer as defined in 33-22-125," in amendment #4. EXHIBIT 6 Ms. Ask explained the differences.

REP. KASTEN asked if it brings the scope down. Ms. Ask said yes.

REP. SMITH asked referred to page 2, new Section 2 of HB 533 and asked if it would be more clear to change the title of the section to "Portability of preexisting waiting period" rather than "Portability of insurance required." Ms. Ask said that it may be better to say "Portability of insurance waiting period required."

REP. BARNHART inquired if the question pertained to the amendment. REP. SMITH apologized and said it didn't.

Ms. Ask clarified that they might want to say "portability of waiver of any time period applicable."

Vote: Question was called. Voice vote was taken. The motion carried unanimously.

CHAIRMAN ORR said they would discuss the bill.

REP. SIMON commented on Section 2 and said that the "headlines" are guidelines and perhaps the staff could suggest some language that would be more instructive. He stated that the headlines do not affect statute.

REP. SIMPKINS inquired about the waiver of preexisting conditions.

Tom Hopgood, Health Insurance Association of America, suggested clarifying the title of Section 2, and call it "Waiver of preexisting condition exclusion."

Motion: REP. SIMPKINS MOVED TO AMEND THE TITLE OF SECTION 2, HB 533 TO READ "WAIVER OF PREEXISTING CONDITION EXCLUSION".

REP. BARNHART inquired about the 30 days. CHAIRMAN ORR inquired if the question had to do with the amendment. REP. BARNHART answered no.

REP. SIMON questioned if an amendment were really in order to change the title since the title change is not statute. He suggested that the staff could make the change without a formal amendment.

REP. SIMPKINS stated that it is a matter of record if it is done by amendment.

Vote: Question was called. Voice vote was taken. The motion carried unanimously.

REP. BARNHART inquired about the 30 days.

REP. SIMPKINS said to change it to "60 days", or change it to "applies for the insurance within 30 days of expiration of the previous insurance." REP. NELSON stated that it is fine the way it is.

REP. SIMPKINS asked if the insurance terminates on the date that a person quits a job. Mr. Hopgood said that the industry has no problem with changing it to 60 days.

REP. NELSON asked REP. SIMPKINS if the premium is paid until the end of the month and asked if he was talking about group insurance. REP. SIMPKINS said yes.

REP. NELSON stated that generally if the premium is due on the first of the month and premiums are paid a month at a time, then if an employee terminated on the second of the month, coverage would last until the end of the month.

Motion: REP. SIMPKINS MOVED TO AMEND HB 533, LINE 7, PAGE 2 TO 60 DAYS.

Discussion: REP. R. JOHNSON inquired what Mr. Cote had to say about the termination of contracts due to unemployment.

Frank Cote said that under certain contracts if someone were to leave employment, the contracts are written in such a way that the coverage would cease at that point of termination. There may be a refund due to the employer or to the employee. A concern he had about using the effective date was that the employee doesn't have any control over that. If it were the date of application,

the employee would know when the date of application was; which may or may not cause another problem for the industry. He indicated the problem that by the time the underwriting is complete, it may be beyond 30 or 60 days.

REP. R. JOHNSON asked what the purpose is for changing 30 days to 60 days, other than to make it 30 days longer? Frank Cote said that is what it would do; make it 30 days longer. REP. R. JOHNSON stated that it does not answer the problem. Mr. Cote agreed that it may not.

REP. R. JOHNSON asked if it would make any difference if it were changed to 120 days. Mr. Cote replied that probably would not be well received.

REP. NELSON explained that if the period is too long, it has an upward impact on everyone's insurance rates. He indicated the shorter the time period, the less impact it will have on the cost of insurance. The reason is the longer the period the greater the risk something will happen. He agreed with Mr. Cote that it would not hurt to go to 60 days.

REP. SIMON asked for Ron Kunik's comments on the issue.

Mr. Kunik, Montana Medical Benefit Plan, stated that it would be fair to the consumer to allow them 30 days to submit their application.

{Tape: 2; Side: 1.}

REP. SIMPKINS referred to line 7, page 2, HB 533, and suggested rewording it to "was continuous to a date and the individual applies for replacement insurance within 30 days after the termination of the previous insurance."

REP. KASTEN suggested to keep the 30 days and go to the date of application.

CHAIRMAN ORR asked how that would read. REP KASTEN said "continuous to the date not more than 30 days prior to the date of application of the new coverage."

REP. SIMPKINS said the focus is on the gap between the termination and applying for new insurance. He said it is not within 30 days of applying; it is within 30 days after the termination of the previous insurance.

At this time REP. SIMPKINS withdrew his motion to amend line 7, page 2, HB 533 to 60 days.

REP. SQUIRES asked if the application time works for the benefit of the consumer. Mr. Cote answered yes.

REP. SQUIRES asked if a person would be covered if they applied on the fifteenth day of the 30 days. REP. KASTEN corrected "the 29th day." Mr. Cote answered yes.

REP. NELSON asked if the premium was due today--February 16--would the application have to be made before the sixteenth of March, or whatever 30 days later happened to be. He indicated that many people would interpret this to mean that they can go up to the sixteenth of April, because they would think that they have insurance during the 30-day grace period. He stated that they would only have insurance during the 30-day grace period if the February premium was paid.

REP. SQUIRES supported REP. NELSON'S comments.

REP. KASTEN asked Mr. Cote if the date of employment termination was also the date of policy termination. Mr. Cote said that it could be in some contracts.

REP. KASTEN stated that to carry any portion of the insurance it would be necessary to be on COBRA or pay the policy for this 30 day period.

REP. NELSON referred to line 7, page 2, HB 533 and suggested changing "30 days" to "60 days" and changing "effective date" to "application date."

CHAIRMAN ORR stated the phrase on line 7, page 2 would read "60 days prior to the application date." REP. SQUIRES asked Mr. Hopgood to clarify.

Mr. Hopgood indicated that if they use the date of application, then it should be 30 days so as not to unduly increase the price of coverage. He suggested rewording it to "previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage."

REP. SMITH said that there has to be termination.

Mr. Hopgood said there would be coverage regardless of how the coverage terminates.

REP. SIMPKINS said that people would get confused about the grace period. People will think that they have 30 days from the end of their grace period.

Mr. Hopgood stated "you are trying to find a one-size-fits-all." He indicated that he has almost 300 different contacts. He suggested wording the phrase to benefit the most people.

Motion/Vote: REP. TUSS MOVED TO ACCEPT THE TOM HOPGOOD LANGUAGE, PAGE 2, LINE 7, TO READ "PREVIOUS COVERAGE WAS CONTINUOUS TO THE DATE NOT MORE THAN 30 DAYS PRIOR TO THE DATE OF APPLICATION FOR

NEW COVERAGE." Question was called. Voice vote was taken. The motion carried unanimously.

Motion/Vote: REP. SIMON MOVED HB 533 DO PASS AS AMENDED. Voice vote was taken. The motion carried 11 to 0.

EXECUTIVE ACTION ON HB 405

Motion: REP. NELSON MOVED THAT HB 405 DO PASS.

Motion: REP. NELSON MOVED AMENDMENT #1. EXHIBIT 7

Discussion: Larry Akey, Montana Association of Life Underwriters, explained amendment #1 and stated the amendment allows large employers to participate in purchasing pools.

REP. SIMPKINS asked if there are other amendments to HB 405 as well. CHAIRMAN ORR stated he wasn't aware of any.

REP. R. JOHNSON inquired if there were anyone in the room who disagreed with these amendments. REP. R. JOHNSON requested that Ed Grogan make a statement.

Mr. Grogan, Montana Medical Benefit Plan, Montana Medical Benefit Trust, and the Montana business and Health Alliance, indicated that he did not have a copy of the amendment, so he did not know if he disagreed or not. (He was given a copy of the amendment). He indicated that at one time there was discussion about changing the number from 1000 to a smaller figure because of Montana's lack of population density.

REP. TUSS indicated that Mr. Grogan was referring to line 26, page 2, of HB 405. She said he is talking about changing it to a smaller number, but it should be changed it to a larger number for more inclusion.

REP. R. JOHNSON inquired if Mr. Grogan's amendment referred to 1000 on page 2, line 25. He indicated that all the amendment did was put in the numerals instead of spelling it out. He asked if that was Mr. Grogan's question.

Mr. Grogan said no. He said there was discussion about changing the number to smaller than 1000 so that there would not be such a big pool. He suggested that instead of 1000, perhaps it should be 500.

REP. R. JOHNSON inquired if there were anyone else who disagreed with any part.

Mr. Kunik stated that he had previously addressed an issue regarding agents soliciting business for the alliance.

CHAIRMAN ORR stated that amendment #12 is in regard to that.

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL

DATE Feb. 16, 1995

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten	✓		
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		



HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Page 1 of 2

Mr. Speaker: We, the committee on Select Committee on Health Care report that House Bill 533 (first reading copy -- white) do pass as amended.

Signed: _____

Sf Orr

Scott Orr, Chair

And, that such amendments read:

1. Title, line 7.

Strike: "AND"

2. Title, line 8.

Following: "MCA"

Insert: "; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN
APPLICABILITY DATE"

3. Page 1.

Following: line 13

Insert: "(1) "Block of business" means an individual disability insurance policy certificate or contract product type written and sold by a health care insurer to a defined set of individuals. All individuals covered by the type of policy or contract are considered to be within the block of business."

Renumber: subsequent subsections

4. Page 1, line 14.

Strike: "health care insurer as defined in 33-22-125"

Insert: "disability insurer, a health service corporation, or a health maintenance organization"

5. Page 1, line 27.

Strike: "standard health benefit plan referred to in 33-22-1811"

Committee Vote:

Yes 11, No 0.

411429SC.Hbk

and 33-22-1812"

Insert: "plan being applied for"

6. Page 1, line 30.

Following: "benefit society"

Insert: ", that provides benefits similar to or exceeding the
plan being applied for"

7. Page 2, line 3.

Strike: "Portability of insurance required."

Insert: "Waiver of preexisting condition exclusion."

8. Page 2, line 7.

Strike: "effective"

Following: "date of"

Insert: "application for"

9. Page 2, lines 14 and 15.

Strike: "by premium" on line 14 through "state" on line 15

Insert: "across the block of business"

10. Page 3.

Following: line 18

Insert: "NEW SECTION. Section 6. Applicability. [This act]
applies to a policy, certificate, or contract of disability
insurance and a health service membership contract entered
into or renewed on or after [the effective date of this
act].

NEW SECTION. Section 7. Effective date. [This act] is
effective January 1, 1996."

-END-

Amendments to House Bill No. 533
First Reading Copy

For the Select Committee on Health Care

Prepared by David S. Niss
February 16, 1995

1. Title, line 7.
Strike: "AND"

2. Title, line 8.
Following: "MCA"
Insert: "; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN
APPLICABILITY DATE"

3. Page 1.
Following: line 13
Insert: "(1) "Block of business" means an individual disability
insurance policy certificate or contract product type
written and sold by a health care insurer to a defined set
of individuals. All individuals covered by the type of
policy or contract are considered to be within the block of
business."

Renumber: subsequent subsections

4. Page 1, line 14.
Strike: "health care insurer as defined in 33-22-125"
Insert: "disability insurer, a health service corporation, or a
health maintenance organization"

5. Page 1, line 27.
Strike: "standard health benefit plan referred to in 33-22-1811
and 33-22-1812"
Insert: "plan being applied for"

6. Page 1, line 30.
Following: "benefit society"
Insert: ", that provides benefits similar to or exceeding the
plan being applied for"

7. Page 2, line 3.
Strike: "Portability of insurance required."
Insert: "Waiver of preexisting condition exclusion."

8. Page 2, line 7.
Strike: "effective"
Following: "date of"
Insert: "application for"

9. Page 2, lines 14 and 15.
Strike: "by premium" on line 14 through "state" on line 15
Insert: "across the block of business"

10. Page 3.

Following: line 18

Insert: "NEW SECTION. Section 6. Applicability. [This act] applies to a policy, certificate, or contract of disability insurance and a health service membership contract entered into or renewed on or after [the effective date of this act].

NEW SECTION. Section 7. {standard} Effective date. [This act] is effective January 1, 1996."

JOINT SELECT COMMITTEE ON HEALTH CARE

CHAIRMAN--STEVE BENEDICT

SECRETARY--JENNIFER GAASCH

NORMAL SCHEDULE => SITE: ROOM 325

DAYS: ON CALL

TIME: T.B.A

- BILL NO-- REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE - REREFERRED - DATE READ

HB0085	RANEY, BOB	3/04	3/09	ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR ACTUAL AMOUNT OF MEDICAL EXPENSES	TABLED ON 03/13	VOTE:		
HB0202	NELSON, THOMAS	3/04	3/09	ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR 1/2 MEDICAL INSURANCE PREMIUMS	PASS AS AMENDED 3/13	VOTE:		3/15
HB0405	NELSON, THOMAS	3/06	3/07	ALLOW VOLUNTARY PURCHASING POOLS, REVISE ASSOCIATIONS FOR GROUP DISABILITY	CONCUR AS AMENDED 3/13	VOTE:		3/16
HB0446	ORR, SCOTT	3/06	3/09	REVISE PREEXISTING CONDITION LAW	CONCUR AS AMENDED 3/16	VOTE:		3/18
HB0466	NELSON, THOMAS	3/06	3/08	AMEND SMALL EMPLOYER HEALTH CARE AVAILABILITY ACT	CONCUR AS AMENDED 3/16	VOTE:		3/18
HB0511	JOHNSON, ROYAL	3/06	3/07	CREATE HEALTH CARE ADVISORY COUNCIL; REPEAL HEALTH CARE AUTHORITY	CONCUR AS AMENDED 3/13	VOTE:		3/16
HB0531	ORR, SCOTT	3/23		PROVIDE FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH CARE SERVICES	CONCUR 3/16	VOTE:		3/24
HB0533	ARNOTT, PEGGY	3/06	3/09	PORTABILITY OF INSURANCE AND PREMIUM INCREASE DISTRIBUTION	CONCUR AS AMENDED 3/16	VOTE:		3/18
HB0542	TASH, BILL	3/04	3/07	MONTANA PUBLIC HEALTH IMPROVEMENT ACT	DO PASS 3/13	VOTE:		3/15
HB0560	SIMON, BRUCE	3/21		AUTHORIZE MEDICAL CARE SAVINGS ACCOUNTS	CONCUR 3/13	VOTE:		3/22
SB0062	DOHERTY, STEVE			ALLOW INDIVIDUAL INCOME TAX DEDUCTION FOR MEDICAL INSURANCE PREMIUMS				

MINUTES

**MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION
JOINT SELECT COMMITTEE ON HEALTH CARE**

Call to Order: By **CHAIRMAN STEVE BENEDICT**, on March 9, 1995, at 5:30 p.m.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
Sen. Mike Foster (R)
Rep. Duane Grimes (R)
Sen. Judy H. Jacobson (D)
Sen. Ken Miller (R)
Rep. Bruce T. Simon (R)
Rep. Carolyn M. Squires (D)
Rep. Carley Tuss (D)

Members Excused: Sen. Dorothy Eck (D)

Members Absent: None

Staff Present: Susan Fox, Legislative Council
David Niss, Legislative Council
Jennifer Gaasch, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: This was a meeting where public testimony was given on HB 446, HB 531, HB 533, SB 322, SB 341, HB 85, HB 202, SB 62, SB 74, and SB 376

Executive Action: None

{Tape: 1; Side: A.}

Public Testimony:

Kate Cholewa, representing Montana Women's Lobby, said on HB 446, page 3, defined at the top of the page "A health benefit plan may not define a pre-existing condition more restrictively than these items." In (b) it talks about an ordinarily prudent person seeking medical advice. On (c) they have pregnancy existing on the effective date of the coverage of the insured person. She said they would like to see pregnancy not treated any differently than other pre-existing conditions. An ordinarily prudent women

if they trace her date of pregnancy back to a week before her policy went into effect she is an ordinarily prudent person with a pre-existing condition who would have still sought medical advice for that condition. They would like to see pregnancy not treated differently.

Tom Hopgood, representing the Health Insurance Association of America, said he would like to address HB 446 and had amendments they would like to offer to that bill. (EXHIBIT #1) He said the amendments were mostly technical. On line 5, page 3, they think that would be a good idea to strike that so they do not write a pre-existing condition on pregnancy. He said the bill sets a pre-existing condition for a health benefit plan, look back for 3 years, exclude it, then for a period of 12 months. It is a little better than it is for other types of disability policies which are on the market. He said he had some amendments to propose. (EXHIBIT #2) He said this bill said once a pre-existing condition is covered under a health insurance policy they, can transfer their health insurance policy to another company and they would not have to satisfy the pre-existing condition again. There is a provision in HB 533, Section 3, page 2, which would address the spread of premium increases. When a person becomes ill some health insurance companies have taken that person's premiums and increased them because of adverse claims experience. In Section 3, the only thing that should increase an individual's policy is an increase in his/her age. Any other reasons to increase that policy have to spread across the entire market. The company cannot take revenge on a person for getting sick. The way the bill was originally written it would apply to group policies. The thought was that group policies were already sufficiently covered under the small group act. He said the amendments would take care of that. He said they had one amendment prepared for HB 531. (EXHIBIT #3) He said that amendment was on page 7, line 30, and has to do with the disclosure requirements. Health care insurers and producers are to provide, at the point of application, a set of materials continuing on page 8. They think that is a lot of material. What it appears they really want is a general history of what is going on with the premiums to particular policies. They feel by the company providing a general narrative of what has gone on with the companies premiums over the past 5 years would be sufficient for that. He said they were still discussing things between the interested parties.

Claudia Clifford, representing the State Auditor's Office and the Commissioner of Insurance's Office, said was going to address HB 446, HB 533, and SB 322. The goal is to address portability. They key to understanding portability is whether or not they can even get their next policy. She that is what the issue of guaranteed issue is about. These bills deal with pre-existing conditions. She said in current law, a pre-existing condition is a problem that has occurred, there is a medical diagnosis, it is something that is documented. In one of the bills they add a definition of what pre-existing means. It would be what any

prudent person would have sought treatment for. That makes it more difficult for the consumer. It is hard for them to seek recourse if they disagree with the insurance company. It is not in the best interest. There is the look back period issue. How far back in someone's history do they look back and say this is a condition which they are either not going to cover or treat differently. In current law it is a 5-year look back period. One of the bills says they would only look back 3 years, but it then deals with rider conditions. It segregates some of the pre-existing conditions. It says that some pre-existing conditions are bad enough that they will not only apply a 12 month waiting period, but they want to note those conditions in the contract and make them wait longer on getting coverage for that. That kind of rider condition in one of the bill says that they will not cover those conditions for 4 years. The insurance company would argue that if they could not rider some conditions, especially in individual policies, they would probably choose to reject that person all together. Riders are not currently dealt with in law. Riders are not allowed because they are not dealt with and all the law says is that if a person has a past medical problem they can only have a 12 month medical problem. They need to deal with riders somehow if they are going to be allowable. If a person has a condition that has not been ridered, the bills have what is an attempt to waive the 12 month waiting period. If a person has had previous coverage and they did not have much of a lapse in coverage they do not have to go through the 12 month waiting period. That is very important for portability and as a good move in the bills. One bill says that the lapse in coverage can be only 30 days and another bill says 60 days. There is also a difference as to when that applies. They recommended they put in the 60 days and that they make it to that date of application. The day of application is controlled by the consumer. Companies vary on how quickly they can issue policies. She said if the idea was not to restrict any more on a person when they are going to their next policy then riders do not do that. Currently, if they leave the bill unamended, insurance companies can look back in someone's past history back to birth and rider any condition. They recommended that they apply the same look back period to ridered conditions as they do to the other pre-existing conditions of 3 years. They acknowledge that there is a complex issue of riders when they move to another policy. Companies have different underwriting policies. The new company may want to rider a whole new set of conditions. When they had the first policy there was only one ridered policy and when they go to the next policy there may be 4 or 5 different riders. Do they want to allow that or do they want to address that there would be no more riders in the next policy. In response to a question regarding which bill she was referring to, **Claudia Clifford** replied essentially she was talking about all three bills at one time. She said they support the concepts in all three bills of improving pre-existing conditions and improving portability. She said with the issue of riders when going to a new policy they want to allow consider that if they have a rider condition on their first policy for 4 years and they have had that policy for

2 years, when they go to the new policy do they receive the same kind of credit that they got from pre-existing conditions and they only have to fulfill 2 more years of a rider condition. She said, dealing with the retroactive applicability of a bill they believe to retroactively to allow for riders is unconstitutional under contract law. She said she had a copy of the GOP health plan in the news. (EXHIBIT #5) She offered amendments to SB 322 (EXHIBIT #5), HB 446 (EXHIBIT #6), and HB 533 (EXHIBIT #7).

Larry Akey, representing the Montana Association of Life Underwriters, said they supported HB 446 and HB 533 when they were before the House Select Committee on Health Care. They support the amendments proposed by Tom Hopgood. He said it is true that an ordinarily prudent person does add a new standard or reintroduces a standard to the statute on pre-existing conditions. He said they did not feel that was a necessary part of the statute when the look back period was 5 years. They felt it was important to bring that standard back in if they were going to change the look back period to 3 years. They believe the rider language as it is currently contained in HB 446 as amended in the proposed amendments by Tom Hopgood are good and solid rider exceptions. He said there was an issue of retroactivity. That is a danger that a force to find a retroactive application of the statute unconstitutional. However retroactive applicability does solve a major problem that was in the market and will remain in the market. Riders were commonly used in insurance policies prior to a departmental interpretation about 1 1/2 years ago. There are a number of policies out there today that have riders on them. They are concerned without retroactive applicability that an insurance company in the future find itself in court over that rider. They suggest a better way would be to not strike the section on retroactive applicability and the question of its constitutionality is to add a section on severability. They think that would address the issue should the courts find that they cannot retroactively apply those provisions they would not have to throw out the entire statute. They support tax deductibility of insurance premiums. They asked that they treat individual premiums, premiums written by self-employed individuals in the same way they would treat health insurance premiums in a corporation or another business. They would like to see health care treated as a deductible expense from the first dollar across the board, but that would be very expensive. It is up to this committee and this Legislature to see how much tax fairness they can afford in the area of health care. He said HB 202 was the bill that addresses insurance premiums. They would at a minimum ask that they address HB 202. SB 376 is an effort to regulate multiple employer welfare arrangements (MEWA). He said there are two reasons that insurance agents care about the regulation of multiple employer welfare arrangements. One is that they have a direct impact with the way they do health care reform in the state of Montana. The tighter things are in the regulated market, the higher they raise the limit on the number of employees in a small employer group under the small employer act. He said the more likely it will be that they will see

leakage into the self-funded market because those self-funded plans are exempted from mandated benefits and other provisions of the state insurance code. He said to the extent that they have multiple employer welfare arrangements out there that are not regulated or are very weakly regulated they are concerned that any efforts they make to provide health care reform will only end up forcing people into the unregulated market and escaping all of the things the Legislature currently is trying to accomplish. Insurance agents that market products for unregulated MEWAS may be exposing themselves financially since they are selling products for what is essentially an unauthorized insurer. Their A and O coverage probably will not cover the consequences of any financial insolvencies. It is important for the agents who are offering MEWAS that they have some sort of regulation on the books so that exposure is not there. He said that SB 376 was considered the great compromise. He said there were 2 groups that were not involved in striking that compromise. There are groups that might like to form MEWAS, but under that bill they would be prohibited. Insurance companies and insurance agents were also not involved. He asked that they give SB 376 some scrutiny. He said the supporters of SB 376 would have the people believe that they did not have to accept any form of regulation and that ERISA wipes out any efforts of the state to regulate multiple employer welfare arrangements. He said it is true that they cannot touch a single employer self-funded plan. He said ERISA says they cannot touch fully-insured MEWAS. He said they cannot regulate them except by regulating the insurance companies that provide them insurance. They cannot touch MEWAS that have been exempted by the Secretary of Labor and there are none of those in Montana. They cannot touch MEWAS that are also employee welfare benefit plans. ERISA defines what an employee welfare benefit plan. MEWAS that are not also employee welfare benefit plans can be regulated by state insurance codes. They supported SB 376 in the Senate with promise to work to strengthen it. There are three areas that the committee should look at. SB 376 sets up a dual track. It says that 4 MEWAS that currently exist. For MEWAS asking for a certificate of authority do not have to comply with demonstrating to the commissioner that they are financially solvent. New MEWAS do have to do that. SB 376 sets up a bona fide association as one of the requirements of being a MEWA. That says they can not form a new bona fide association and create a MEWA for 5 years. The bill creates certain exceptions and exemptions from the insurance laws. The compromise does provide some coverage by the insurance laws. He said on page 8, section 14, title 33, chapter 8, of SB 376, they say that they are going to comply with that except for the fact that they do not want to comply with 33-18-242. 33-18-242 is the section of the statute that gives an individual that has been injured by an insurance company an independent cause of action. They think if it is good for the insurance companies it is good for multiple employer welfare arrangements that are not also employee welfare benefit plans. They ask that they would also consider extending some of the sections of the insurance code to MEWAS. They have said in SB 376 that they are willing to subject

themselves to examinations, but not to approval of forms. It seems that they need both. They exempt themselves from contract language. One of the sections they are willing to comply with is privacy and information chapter. All of those are things the committee should look at and they would submit amendments in those areas. They think there should be some disclosure to the people who are receiving their health care through multiple employee welfare arrangements. They think a MEWA should disclose on the face of the policy or contract that it has with its insured that it is a multiple welfare arrangement that is not an insurance company and that it is not covered by all the guarantees of the statute affecting insurance companies and it is not covered by the guarantee association. He said they are issues they need to address if they are going to report out SB 376. They can either make it clear that SB 376 only applies to those MEWAS that are also employee welfare benefit plans and that all the laws of insurance in Montana affect those MEWAS that are not also employee welfare benefit plans or they can work to tighten up SB 376 in the ways he recommended.

Susan Good, representing Heal Montana, read her written testimony. (EXHIBIT #8)

Tanya Ask, representing BlueCross BlueShield of Montana, said they supported HB 446 and agree with the proposed amendments. They support HB 533 and agree with the proposed amendments. She said riders were important because in the individual market place is not a guaranteed issue market place. Riders allow individuals that might not get coverage to be able to get coverage for everything else except that ridered issue. She said they supported the retroactive applicability. They feel there are problems due to the way that particular provision had been interpreted over the last year. She said she would like to comment on having portability of the riders. She said under riders, those individuals are not guaranteed issue. Even though that would allow portability in the individual market it does not say that say that an insurance company would necessarily going to take that risk. Insurance companies have different underwriting criteria. One may accept someone with a rider and another may not accept that without a rider. She said she said the Comprehensive Health Care Authority is a pool of last resort. They have been in the process of making the benefits better under state law. She said they were trying to move those benefits up. She said that they would like to do that and they are asking to keep the potential cost in mind. They would like SB 341 that contains other provisions that the board felt changes were necessary to in order to make the operation more viable. Tax deductibility will be decided on the overall financial constraints on Montana. She said they have endorsed HB 202 dealing with strictly the deductibility of premiums for individuals. She said this was an area of concern by small businessmen who had their own individual contracts. They would like the same benefit as larger groups have. She said they would support SB 376 with the attached amendments. They would like those types of arrangements to be on

equal footing. There are already new potential to be on equal footing with those already in the self funded multi-employee welfare arrangement market place. The amendments provide basic protection such as privacy protection, newborn coverage and other things that Montana's previous legislatures have felt were important. ERISA qualifying MEWAS are precluded from some portions of state law, but not every single MEWA is.

{Tape: 1; Side: B; Approx. Counter: .1; Comments: Tanya Ask was cut off while she was talking.}

She said this legislation grants a certificate of authority. That is a license to be an insurer. When they are licensed as an insurer, consumers think it is an insurance company that is subject to all of the regulations of the state and the protection are afforded thereby. She said they were concerned with the certificate of authority. She asked that they take a look at the way it was written because they feel it may preclude some people from becoming a MEWA until they have been a bona fide association for a period of 5 years. She said there are things that people feel they cannot live with under the insurance regulation. She said one of those things was a form filing requirement. The insurance department reviews the benefit agreements that Montana consumers would receive. Another was how the contract would be laid out so that people would have an idea what the benefits under that contract would be. Another was a law that regulated how insurance companies, health service organizations, HMO's, and others conduct utilization review. She said there were very strict requirements put on there for the benefit of Montana consumers. They asked that the particular set of amendments be given careful consideration.

Tim Filz, a attorney with the Brown law firm in Billings and represents an number of MEWAS, he said he would talk about SB 376. He said a MEWA was a Multiple Employer Welfare Arrangement. Any time two or more employers get together and provide welfare benefits for their employees that is a MEWA. He said the exception to that is if the employers are related or controlled entities. He said ERISA says that state law cannot regulate employee welfare benefit plans. ERISA says that notwithstanding that prohibition states can regulate insurance companies. The states can heavily regulate insurance companies even though there is an impact on a welfare benefit plan. Any employer that adopts a plan to provide health benefits for its employees is a welfare benefit plan whether that is fully insured or self funded. The state or the federal government says that Montana cannot directly regulate any employer to the extent that they provide welfare benefits to their employees. The federal government says that the state can regulate the insurance companies. The federal government says that the states can regulate multiple employer welfare arrangements to the extent that those requirements are not inconsistent with ERISA. ERISA says that under no circumstances can the state label, call, or describe a welfare benefit plan as an insurance company. That means if they have a

welfare benefits plan, it is not an insurance company and it can not be regulated as an insurance company. A single employer or certain types of multiple employer plans are also welfare benefit plans. He said the MEWA bill in defining what entities are allowed to register as MEWAS is limited to those kinds or arrangements which would qualify under ERISA as welfare benefit plans. A welfare benefit plan which would involve multiple employers is limited to arrangements that are either single industry, or if there is a bona fide employment-related bond between the employers. He said if there is that kind of relationship, then they would be a welfare benefit plan under ERISA entitled to ERISA pre-emption.

ERISA says you can regulate MEWAS if they do not violate ERISA and if they are not called insurance companies. That is the reason they allow a little bit of regulation, not a lot. He said they can be regulated if they are done consistent with the fundamental concepts and not inconsistently with ERISA. With the MEWA legislation they have defined what MEWAS are which is not currently done. They provide for a certification process. MEWAS that do not come through the process are going to be ruled unauthorized insurers. The bill provides for minimum reserves and for minimum funding. That is very crucial. It provides for reporting requirements. The act provides for penalties for MEWAS that do not comply and provides for remedies in the form of liquidation procedure for a MEWA. They agree to that regulation because it will ensure that only good, viable, healthy MEWAS exist. He said there is a dual tract because there are a number of MEWAS out there and they are not sure how many individuals are being provided benefits under existing MEWAS. They think that by coming up with some rules, such as an association must be in existence for at least 5 years prior to sponsoring a MEWA. They think that is a sound rule, but would like it to be around 2 or 3 years. They exempted existing MEWAS because if there is a MEWA that was formed 4 1/2 years after the association was formed and was providing benefits to 500 individuals, are they going to say that they were going to disallow that MEWA that otherwise would meet the requirements. He said they need to say that the ones that were in existence before then can meet the requirements they will allow them to exist. They do not want to encourage the rush to form MEWAS. They are not strongly against disclosure. He said the kind of language in 33-11-1047 with respect to risk retention groups is probably an appropriate type of language to use. He said that they did agree to have all of the Fair Practices Act provisions incorporated into the MEWA bill except for the private cause of action. That is because ERISA provides a private cause of action for individuals agreed by a welfare benefit plan. He said the states can regulate MEWAS, but if it is inconsistent with ERISA. ERISA provides a comprehensive private cause of action and in having done that it is inconsistent for the state to have to create an independent private cause of action. There are things that are allowed under ERISA that are not allowed under a claim against an insurance company.

Lloyd Lockrem Jr., representing the Montana Contractors Health Care Trust, said he would like to address section 33-18-242. He said the primary function of ERISA is to protect the participant once an employer has decided to have employee benefits. He said ERISA does require full disclosure. He said "U.S. district courts have exclusive jurisdiction over civil and criminal action brought under Title 1 of ERISA. Except that cases pertaining to benefit recovery brought by participants may also be brought in state courts. U.S. district courts have jurisdiction to grant relief without respect to the amount in controversy or the citizenship of the parties. The court may decide who shall pay the court costs and legal fees. If you as a participant are successful the court may order the person you have sued to pay these costs. If you lose the court may order you to pay these costs and fees for example that finds your claim frivolous. In addition to creating rights for the plan participant, ERISA imposes duties upon the people who have the responsibility for the operation of the employee benefits plan. The people who are on the plan are called your fiduciaries of the plan and have a duty and in the interest of you and other planned participants. No one else including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA." He said they have set up a review procedure and each time they sit, they sit not as an employer, but as a trustee representing the participant. Legal action to recover lost benefits under this plan may not be brought until they have gone through the administrative procedure. They do not have to appear, but they always have that right. He submitted if and when the insurance industry provides employee benefits at affordable costs to employers in Montana who genuinely want to provide benefits, particularly health care, MEWAS will go away. He said they would commit to the committee if there was any possibility to resolution between the parties they would pledge to work towards that.

Jerry Driscoll, said he had heard a statement made that it was not known if there was any plan approved by the Secretary of Labor. Under the definition, collectively bargained, or by rural electric, or by rural telephone cooperatives are exempted from any state regulation. There are probably 29 of them so far that were approved by the United States Secretary of Labor. He said MEWAS work best when the group of employers form this and then they provide health insurance to their employees and there is portability between the employers because of the skills normally needed by those employers and the employees of anyone can transfer within that. It does not matter what the employer is, it is the skill that they want. The insurance is then portable between the employers. He said there should be some commonality of the employers.

CHAIRMAN BENEDICT replied that he understood there were some amendments that people would like to propose and they would like to have the amendments before executive action.

Lloyd Lockrem replied they would get them the amendments as soon as they could. He said he was trying to resolve an issue that has been in there.

Diane Ruff, representing Associated Employers of Montana, read from a handout. (EXHIBIT #10)

Gary Spaeth, the Chief Council at the State Auditor's Office, said the MEWAS they had come in contact with serve the people well. There are some that are not in Montana that have caused problems. When a MEWA goes insolvent that is where the problem occurs. He said that was what the bill was set up for. How to insure solvency. He said there is a MEWA scam business in other places. He said they were concerned if they did not have some control, it would happen in Montana. He said there are 22 cases that are the leading cases that are in a small area. He said they could either proceed to litigate a lot of issues or they could have a chilling effect. The major concern was solvency. He said the bill does what they set out to do. He said they did not want to seek to have extensive regulation for the fact that they are not in a regulatory climate. He said they looked at approval of forms and paper concerns which are important ways to regulate, but they are not equipped with staff to do that. He said this was a good starting point on regulating MEWAS. He said they do not even have a list of the MEWAS in Montana. He said the amendments (EXHIBIT #11) have been approved. He said they need a statement of intent because they set up a solvency standard, but if they become insolvent they did not put in the liquidation provisions of the statute and they have to adopt them by rule. The other provisions allow flexibility.

Bob Turner, representing the Department of Revenue, said he would address tax deductibility which included HB 85, HB 202, SB 62, and SB 74. He said he would like to give an idea of what is presently allowable in Montana law. (EXHIBIT #12) He addressed each bill and gave amendments that included an explanation of the amendments at the bottom of the page. (EXHIBITS #13-16)

Rick Larson, representing EBMS, said his company is Employee Benefit Management Services and they are in the business of administering employee benefit plans for single and multiple employer welfare arrangements. He said a lot of the protection comes under the Department of Labor and under ERISA. He said a lot of the things that are not covered in the bill are covered under federal law. He urged the passage of the bill with minimal amendments.

REPRESENTATIVE PEGGY ARNOTT, HD 20, said she was the sponsor of HB 533. She said in HB 533 the premium increases must be

distributed proportionably. She said insurers would not be able to selectively raise premiums on one individual with health problems. They would have to distribute the premium increases proportionally. It would make it so no one would be penalized for getting sick. She said the requirement that an individual has qualified for an insurance once they have done that and maintained coverage they do not have to go through another qualifying period. This bill is a small step forward. The 30 days was amended in committee. She said that was an acceptable length of time as amended.

Ed Grogan, representing the Montana Medical Benefit Plan and the Montana Medical Benefit Trust, said they Montana Medical Benefit Trust was a fully insured MEWA and the Montana Medical Benefit Plan provides the insurance for that MEWA. He said there are reams and reams of federal legislation and Department of Labor rules on MEWAS and before they were to make any dramatic changes, they should have a lawyer check to make sure they were not violating laws. He said the present law as in 33-22-110 says it is not a pre-existing condition unless they have seen a doctor. He said people are sick before they go see a doctor. The new rules allow for a ordinarily prudent person would determine whether or not the condition was pre-existing condition when filling out their application. The problem with waiting to see a doctor is they have had 3 claims that they have had to pay in the last year because it is only in the last year that it has applied. He said the law as it stands lets people with pre-existing conditions purchase insurance. He said previous to this year riders had allowed in Montana. They have said that riders and pre-existing condition are one in the same and they could only have a rider for 1 year. The changes are to make it so that they could not have riders. The law says 4 years and they believe that there should be no limit on the length of time for a rider. He said to put a 4 year limitation on a rider would be the same as saying that they would have to deny that person coverage. He said the new language in the bill that says a person can basically go 60 days without insurance and then sign an application should say that they be out of the market only 30 days and if they have an application within that 30 days period they would still be qualified. They support tax deductibility and any bill pertaining to that.

EXHIBIT #17 was passed out to the committee.

CHAIRMAN BENEDICT said he would open it up to anyone who wanted to address health care in general.

Tanya Ask, representing BlueCross and BlueShield of Montana, said she would like to address cost containment and early intervention and prevention. A group of people who have not been present are children who are not insured and not covered by Medicare or Medicaid. The Caring Program for Children sponsored by the Caring Foundation of Montana. This program is a private effort that is a cooperative effort on the part of physicians,

hospitals, insurance agents, physician assistants, nurse practitioners and the whole health care community as well as individuals and groups around the state. She said the program was a non-profit program which was started 1 ½ years ago. She said the idea was that frequently children do not receive primary preventive health care benefits when their parents are in transition. The program provides benefits for well child visits, regular office visits, x-ray lab services, and out-patient surgery. It is not designed to be 100% coverage, but it is designed to take care of most of the services that most children need. The cooperation of health care providers is important because those who participate in the program receive a lower level of reimbursement to cover the children. They know that they are going to be paid for taking care of that child, they will not have to worry about deductibles or co-payments, and that takes care of an administrative burden. This program has provided benefits for over 600 children in Montana. The reason they are bringing the program to the committee is to notify them that the more dollars that come in the more they have to help the children. They are bringing the idea of a public private initiative. The idea would be to have a match and that there are so many public dollars before private dollars are put in.

Jeffrey H. Strickler, M.D., read his written testimony.
(EXHIBIT #18)

{Tape: 2; Side: A.}

CHAIRMAN BENEDICT said that there was not a vehicle for this issue in the legislature. The wisdom of the people that chose the bills that came into this committee were such to take the bills that were alive in the process. He said that these presentations could best be made to the appropriations committee if SENATOR DOROTHY ECK'S bill made it to that process. He thanked them for making those concerns.

Questions from the Committee:

None

JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL

DATE 3-9-95

[illegible]

HIAA/MALU/BC&BS
AMENDMENTS
HB 533

1. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"
2. Page 1, line 20.
Strike: "TYPE OF"
3. Page 1, line 23.
Following: "CORPORATION,"
Strike: "OR"
4. Page 1, line 23.
Following: "ORGANIZATION"
Insert: "or a fraternal benefit society"
5. Page 1, line 26.
Following: "issued"
Strike: "or delivered for issue"
Insert: "for delivery"
6. Page 1, line 26.
Following: "individual"
Strike: Lines 27 and 28.
7. Page 1, line 29.
Following: "self-"
Strike: "insured"
Insert: "funded"
Following second: "self-"
Strike: "insured"
Insert: "funded"
8. Page 2, line 8.
Following: "FOR"
Strike: "if the insurance or plan has been in effect for a period of at least 1 year"
9. Page 2, line 11.
Following: "FOR"
Strike: "if the plan has been in effect for a period of at least 1 year"
10. Page 2, line 22.
Following: "charges for"
Strike: "a group or"
Insert: "an"

11. Page 2, line 24.
Following: "charges for"
Insert: "individual"
12. Page 3, line 8.
Following: "means a"
Strike: "health care insurer as defined in 33-22-125"
Insert: "disability insurer, a health service corporation,
a health maintenance organization or a fraternal
benefit society"
13. Page 3, line 29.
Following: "chapter 22, part"
Strike: "1"
Insert: "2"
14. Page 3, line 30.
Following: "chapter 22, part"
Strike: "1"
Insert: "2"
15. Page 3, line 30.
Insert: "(3) The provisions of Title 33, Chapter 1, parts
3 and 7, apply to [Section 3]."

State Auditor's proposed amendments to HB 533

1. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"
2. Page 1, Line 23.
Following: "INSURER,"
Insert: "a fraternal benefit society"
3. Page 1, Line 26.
Following: "issued"
Strike "or delivered for issue"
Insert: "for delivery"
4. Page 1, Line 27.
Following: "any"
Strike: "discretionary group trust policy"
5. Page 1, Line 29.
Following: "self-"
Strike: "insured"
Insert: "funded"
6. Page 1, Line 29.
Following: "self-"
Strike: "insured"
Insert: "funded"
7. Page 2, Line 8.
Following: "For"
Strike: "if the insurance or plan has been in effect for a period of at least 1 year"
8. Page 2, Line 11.
Following: "For"
Strike: "if the insurance or plan has been in effect for a period of at least 1 year"
9. Page 2, Line 19.
Following: "than"
Strike: "3"
Insert: "6"
10. Page 3.
Following: line 8
Insert: "(3) The Provisions of Title 33, Chapter 1, Parts 1 and 7 apply to this section."

11. Page 2.
Following: Line 20
Insert: "NEW SECTION. Section 3. An insurer shall waive any time period applicable to a rider for the period of time that an individual was covered by a previous policy or certificate, crediting any period of time that was covered by that policy or certificate toward the rider period of the replacing policy or certificate."
ReNUMBER: subsequent sections
12. Page 3, Line 8.
Following "insurer"
Strike: as defined in 33-22-125"
Insert: "disability insurer, a fraternal benefit society, a health service corporation, or a health maintenance organization"
13. Page 3, Line 12
Following: "section"
Strike: "3"
Insert: "4"
14. Page 3, Line 26.
Following: "1"
Delete: "and"
Insert: ", "
15. Page 3, Line 26.
Following: "2"
Insert: "and 3"
16. Page 3, Line 28.
Following: "1"
Delete: "and"
Insert: ", "
17. Page 3, Line 28.
Following: "2"
Insert: "and 3"
18. Page 3, Line 29.
Following: "Section"
Strike: "3"
Insert: "4"
19. Page 3, Line 30.
Following: "section"
Strike: "3"
Insert: "4"

PRE-EXISTING CONDITIONS

The issues of portability and pre-existing conditions are important features of the HEAL Montana program. We support HB 533 and HB 446.

People need to be able to take their insurance with them as they change careers throughout their lifetimes. Being able to be "benched" for one waiting period should be sufficient, rather than the old ways of starting the clock over each time.

HEAL is interested in the amendments offered by the insurers, and we generally support them, but there is one glitch. Portability will be taken care of for individuals, groups from three to twenty five, and large groups. The segment unaddressed is the two person group. There seems to be no sympathy to lower group to two, and preliminary discussion reveals the difficulties that are peculiar to that set. Addressing that problem should probably be left to another time.

MCHA

MCHA needs serious attention. Its benefits are poor and the premiums exorbitant. Both sides need adjustments. Current premium rates are 150 to 400% of regular premiums. Surrounding states are capped at 125- 135%.

MCHA benefits and its programs were and will continue to be the subject of intense debate at the working meeting. *Support 531*

DEDUCTIBILITY

#B202
HEAL is supports Tax Deductibility for premiums for health insurance premiums.

M. SUSAN GOOD
HEAL MONTANA
JOINT HEALTH CARE COMMITTEE
MARCH 9, 1995

TESTIMONY
STATE FARM INSURANCE COMPANIES
BEFORE THE JOINT HEALTH CARE COMMITTEE
REGARDING HB 533
MARCH 9, 1995
Room 325
5:30 p.m.

Chairman Benedict, Members of the Joint Health Care
Committee:

On behalf of State Farm Insurance Companies in Montana, I
thank this Committee for allowing me this opportunity to present
written testimony regarding some of State Farm's concerns on
House Bill 533. Specifically, State Farm's concerns arise from
New Section 3 beginning on page 2, line 21 of the bill. With
regard to New Section 3(1), we believe that the intent is to
apply any rate increase that might occur on an across-the-board
basis. However, occasionally the experience indicates that some
policies should get less of an increase than others. For
example, the experience on a \$500 deductible policy may be
different than the experience on a \$1,000 deductible policy.
Therefore, it seems more equitable that rate increases should be
reflected accordingly between these two types of policies.
Perhaps one option might be to make rate adjustments "form
specific" as opposed to across-the-board. In this regard, State
Farm suggests that the last sentence of New Section 3 be deleted
and that the following sentence be added:

Increases in premium, certificate, or contract
rates for a block of policies, certificates, or
contracts previously issued by that insurer, based
on factors other than attained age, must be dis-
tributed proportionately by premium amount to that
entire block of policy, certificate, and contract

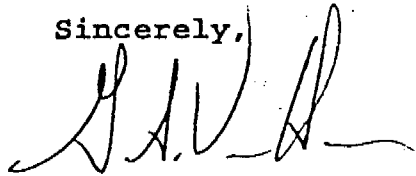
holders of that insurer in the state, except where approved by the commissioner.

State Farm believes that the above language would result in a more equitable distribution of any rate increases required by House Bill 533.

Finally, State Farm would suggest that in New Section 3(2)(ii)(A) the term "hospital confinement indemnity" should be added to that section in order to make it consistent with the wording of New Section 1(3)(b).

On behalf of State Farm Insurance Company, I thank this Committee for the opportunity to provide this written testimony. As always, State Farm looks forward to the opportunity to work together with this Committee in formulating workable legislation which will ultimately benefit Montana's consumers.

Sincerely,

A handwritten signature in dark ink, appearing to read 'G. A. Van Horssen', written in a cursive style.

Gregory A. Van Horssen

GVH/vjz

Testimony before the Joint Committee on Health Care

9 March 1995

Jeffrey H. Strickler, M.D.

Sen. Benedict and Members of the Committee:

I come before you as a practicing pediatrician in Helena to speak for the needs of children.

The activities of this legislature on the issue of insurance reform are laudable, but do not speak to the health care needs of Montana's children. Of the many "uninsured" that drove the discussion of health care reform last session, the bulk (some say 70%) are children. Of the patients inappropriately using emergency rooms, many are children who cannot get into physicians offices. Preventive health services for children such as immunizations and well baby care can not be addressed by your current efforts because of Federal ERISA exemptions for self insured companies... and this represents about half of the insured children in this state. Every year that we have talked about this "problem" more and more companies have dropped dependents (the children) from their benefits, or have required the employee to pay ever more for protection for the family.

I have practiced pediatrics in Helena for the past 20 years. Let me give you an example of the reality of financing children's health at the Helena Pediatric Clinic. A review of the year's end books for 1994 showed that only 40% of our payments came from insurance, 20% from Medicaid, and a whopping 40% was cash - out of pocket expense for parents. With specialty care and adult medicine, Medicare and greater levels of insurance make cash payments much less - I have heard on the order of 5-10%. From our little clinic we are talking on the order of hundreds of thousands of dollars. Spread out over the state, the out of pocket cost for health care for our children is staggering. And it is the out of pocket expense that keeps parents from seeking care when they should.

Let me close by saying that I did not come here asking only for State help. I am also on the Board of The Caring Program, a volunteer effort that seeks donations to provide health insurance for children of the "working poor". So far with the help of Blue Cross/Blue Shield of Montana we are providing insurance for nearly 500 kids and hope to expand this further. This is only a start, and not a solution, but I would urge you to look at enabling public/private partnerships with efforts like The Caring Program so that more of our children can be assured access to quality health care.

I will not presume to solve this problem for you now. I personally think that all children should be guaranteed coverage. But as you go about your deliberations about insurance reform, remember that the children are being left out, and the children deserve our greatest efforts.

DATE March 9, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: HB 446, HB 531, HB 533, SB 322, SB 341, HB 85, HB 202, SB 62, SB 74, SB 376

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
Rock Larsson	EBMS	376	✓	
TIM FILZ	AEM	376	✓	
J.H. STRICKLER	Am Academy of Pediatrics			
Diane R. Ruff	AEM	376	✓	
Kate Cholewa	MT Womens Lobby	446		Sec 1
M. Susan Good	HEAC	446 533 ³¹	✓	2c
LARRY AKEY	MALU	446 533		
Sonny Lockrem	Mont. Contractors	58 376	✓	
Bob Bachinski	Mont. Med. Assoc. - Bizemca	58 376	✓	
Linda Murante				
Michael Keedy	MUST	SB 322		X
Greg	"	HB 446	X	
Greg Van Horssen	State Farm Insurance			
Tom Hopgood	HIAA	446 533	✓	
Bob Turnier	MT Dept. of Revenue	HB 446 533	✓	

Tom Ebzey

YELLOWSTONE Health
VISITOR REGISTER Plan

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE March 9, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: _____

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
Steve Yeakel	MT Council for Maternal & Child Health		Caring Program for Kids	
Taryn Ask	Blue Cross & Blue Shield			
John Flink	MT Hosp. Ass'n.			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

Discussion:

CHAIRMAN BENEDICT said that technically a rider is not part of a policy and that is why it is a rider. The language said it was part of the policy.

Rick Hill said that was not the case. That would be an amendment to the policy itself and therefore become part of the policy.

CHAIRMAN BENEDICT said the language read "elimination rider was a division of a policy".

Rick Hill said it should read "attached to a policy".

{Tape: 1; Side: B.}

Vote:

The MOTION CARRIED UNANIMOUSLY.

Motion/Vote:

REP. ORR MOVED HB 446 DO PASS AS AMENDED. The MOTION CARRIED UNANIMOUSLY.

SEN. MILLER would carry HB 446 on the Senate floor.

EXECUTIVE ACTION ON HB 533

Discussion:

CHAIRMAN BENEDICT said how does this bill differ from the HB 446.

Rick Hill addressed the amendments (EXHIBIT #7 & #8). He said they were using HB 533 as a vehicle because HB 531 would become an independent bill for disclosure. He said that HB 533 deals with portability and pre-existing conditions. The uniform plan has to address the individual market. HB 466 only deals with small group.

SEN. JACOBSON asked why they did not put pre-existing conditions and portability together.

CHAIRMAN BENEDICT said there were some different circumstances between the individual and the group market.

Rick Hill discussed the amendments. (EXHIBIT #8)

Motion/Vote:

REP. SQUIRES MOVED the amendments (EXHIBIT #7 & #8). The MOTION CARRIED UNANIMOUSLY.

Motion:

REP. ORR MOVED HB 533 DO PASS AS AMENDED.

Discussion:

SEN. MILLER asked why January 1, 1996 was the effective date?

Rick Hill replied that was a new contract year and that is the reason for the effective date.

CHAIRMAN BENEDICT said that some of the other bills did not involve contracts and just changed different provisions of law and can be effective on a normal effective date.

SEN. MILLER said that HB 446 had to do with policies and it's effective date was on passage and approval.

Larry Akey replied that the effective date fully applied to the language in the retroactivity applicability.

CHAIRMAN BENEDICT said the whole act had the effective date of passage and approval. The retroactive applicability only applies to riders and yet the effective date of the whole act is passage on approval. CHAIRMAN BENEDICT said that it was not necessary to change the effective date.

Vote:

The MOTION CARRIED UNANIMOUSLY.

SEN. MILLER would carry HB 533.

Discussion:

REP. SIMON said there are some of the bills that have undergone a lot of changes he wondered if they should have a "gray bill" copy given to the members when the bills go to the different floors.

CHAIRMAN BENEDICT said that was something he would have to discuss with the leadership and the legislative council.

ROLL CALL

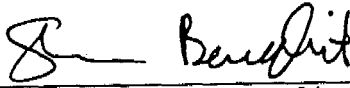
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JOINT SELECT COMMITTEE REPORT

Page 1 of 8
March 17, 1995

MR. PRESIDENT:

We, your Joint Select committee on Health Care, having had under consideration HB 533 (third reading copy -- blue), respectfully report that HB 533 be amended as follows and as so amended be concurred in.

Signed: 
Senator Steve Benedict, Chair

That such amendments read:

1. Title, line 11.

Following: "INSURER;"

Insert: "REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES;"

2. Title, line 11.

Strike: "SECTION"

Insert: "SECTIONS"

3. Title, line 12.

Following: "33-22-101,"

Insert: "33-22-508, AND 33-30-1007,"

4. Page 1, line 19.

Following: "CONTRACT"

Strike: "PRODUCT TYPE"

Insert: "filed and approved by the commissioner pursuant to 33-1-501 and"

5. Page 1, line 20.

Strike: "TYPE OF"

6. Page 1, line 23.

Strike: "OR"

Following: "ORGANIZATION"

Insert: ", or a fraternal benefit society"

7. Page 1, line 26.

Following: "issued"

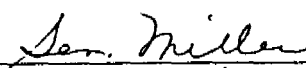
Strike: "or delivered for issue"

Insert: "for delivery"

8. Page 1, lines 27 and 28

Strike: "or" on line 27 through "individuals" on line 28


Amd. Coord.
Sec. of Senate


Senator Carrying Bill

621146SC.SPV

9. Page 1, line 29.

Strike: "self-insured" in two places

Insert: "self-funded" in two places

10. Page 2, line 8.

Following: "FOR"

Strike: the remainder of line 8 through "year"

11. Page 2, lines 11 and 12.

Following: "FOR"

Strike: the remainder of line 11 through "year" on line 12

12. Page 2, line 22.

Strike: "a group or"

Insert: "an"

13. Page 2, line 24.

Following: "charges for"

Insert: "individual"

14. Page 2, line 27.

Following: "BUSINESS"

Insert: "as defined in [section 1]"

15. Page 3, line 8.

Following: "means a"

Strike: the remainder of line 8

Insert: "disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society."

16. Page 3, line 9.

Insert: "(3) The provisions of Title 33, chapter 1, parts 3 and 7, apply to this section."

17. Page 3, line 25.

Insert: "

NEW SECTION. Section 5. Disclosure standards -- individual policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the

amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. Section 6. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during

the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. Section 7. Disclosure standards -- health maintenance organizations. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate health benefit plan.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage

provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. Section 8. Uniform health benefit plan -- individual. (1) Each insurer or health service corporation delivering or issuing for a delivery in this state an individual disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).
(2) The uniform health benefit plan must:
(a) provide coverage for the services and articles required by 33-22-1521(2);
(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed \$1,000 per person or \$2,000 per family;
(c) include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and
(d) be subject to a maximum lifetime benefit of \$1 million.

NEW SECTION. Section 9. Uniform health benefit plan -- group. (1) Each insurer or health service corporation delivering or issuing for a delivery in this state a group disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).
(2) The uniform health benefit plan must:
(a) provide coverage for the services and articles required by 33-22-1521(2);
(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed \$1,000 per person or \$2,000 per family;
(c) include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and
(d) be subject to a maximum lifetime benefit of \$1 million.

NEW SECTION. Section 10. Uniform health benefit plan -- health maintenance organization. Each health maintenance organization delivering or issuing for a delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan [providing benefit equivalency and benefit value, as defined in section 1 of House Bill No. 466] comparable to the uniform health benefit plan required in [section 8(2)].

Section 11. Section 33-22-508, MCA, is amended to read:
"33-22-508. Conversion on termination of eligibility. (1) A

group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person, ~~his~~ or the person's dependents, or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer shall make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 12. Section 33-30-1007, MCA, is amended to read:

"33-30-1007. **Conversion on termination of eligibility.** (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ or a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class

or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such a person~~ that the person shall, provided ~~he~~ that the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person, his or the person's dependents, or family members, ~~provided application.~~ Application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at the insurer's then customary rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

NEW SECTION. Section 13. Coordination instruction. If House Bill No. 466 is passed and approved, then the bracketed language in [section 10], referring to benefit equivalency and benefit value, must be codified."

Renumber: subsequent sections

18. Page 3, lines 29 and 30.

Strike: "1"

Insert: "2"

19. Page 4, line 1.

Insert: "(3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8].

(4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

(5) [Sections 7 and 10] are intended to be codified as an integral part of Title 33, chapter 31, part 3, and the provisions of Title 33, chapter 31, part 3, apply to [sections 7 and 10]."

-END-

Insurance Reform Testimony
Rick Hill *exhibit one*
March 16, 1995

The issues surrounding small group reform and the Small Employer Health Insurance Availability Act go beyond one bill. The amendments I will present and explain deal with five bills:

- HB446 -- preexisting conditions
- HB466 -- small group insurance reform revisions
- HB531 -- general reform proposal
- HB533 -- general health plan revision and individual insurance market reforms
- SB341 -- Montana Comprehensive Health Association revisions

The amendments address five general areas within small group and general health insurance market reforms:

1. Benefit design
2. Reinsurance program
3. Conversion coverage
4. Disclosure/Comparison information
5. Montana Comprehensive Health Association

The issues were addressed with the intent of providing more affordable health care benefit options in the individual and group markets.

The amendments strengthen the Small Group Availability Act to address concerns that the cost of guaranteed issue is being borne solely by the small group market. They allow comparison of one uniform product from insurer to insurer. They provide a guaranteed price for a leaner benefit conversion plan, providing comparable disclosure information from one insurer to another when a consumer is shopping for health insurance, and they enhance the benefits for folks who are served by the Montana Comprehensive Health Association.

I will deal with amendments one bill at a time, but first I need to explain the health benefit plans which run throughout several of these bills. We started with the current Montana Comprehensive Health Association benefit plan, and separated it into two parts, actual benefits and financial criteria or insured financial responsibility, which means deductibles, copayment levels, lifetime maximums and the like.

Benefit Plan Explanation

An outline of all the benefit plans is attached to the testimony for your information.

Uniform Benefit Plan -- The Uniform Benefit Plan must be made available to all individuals and all groups (of 3-25 employees) by health insurers and HMOs. This plan will be non-guaranteed issue, and is designed as a low cost catastrophic benefit plan for individuals, and for small groups who want to be subject to underwriting standards.

Financial criteria for this product:

- 50/50 copayment after a \$1,000 deductible per individual,
- \$2,000 per family with a one million dollar lifetime maximum benefit.

Contract benefits for this product:

- hospital and physician services
- a limited prescription drug benefit.
- Rehabilitative services and a number of other (medical) goods and services are covered
- Transplants, if needed, up to \$150,000 in a lifetime, plus \$10,000 for donor costs.

When people who will buy this type of policy think about covering health care costs, they are thinking about the emotional and financially catastrophic events. A transplant clearly falls in that category.

The traditional mandated benefit of psychiatric and chemical dependency is not included in this benefit design, just as it is not included in the Montana Comprehensive Health Association coverage. All other mandated benefits have also been removed for the purpose of designing this low cost benefit plan, which can be medically underwritten. Again, remember this is catastrophic coverage.

The requirement that the Uniform Plan must be made available is part of the amendments to HB533. This plan is also referenced in HB466.

Montana Comprehensive Health Association Plan – the Montana Comprehensive Health Association is a high risk pool established by the 1985 Legislature to provide health insurance for individuals, who, because of health history or conditions, could not obtain private health insurance.

The current level of benefits are enhanced under this package proposal to provide coverage for listed transplants, again with a lifetime benefit of \$150,000. The Association board of directors is given the latitude to design a lower cost plan by varying the financial cost sharing arrangements with the insureds. At a minimum, the board will still provide a plan which contains the current financial cost of a \$1,000 deductible with 80/20, but the maximum lifetime benefit for that option has been moved to \$500,000.

The enhancement of the MCHA plan has been moved from HB531 into SB341 so it fits with other modifications proposed by the Association board.

Basic Health Benefit Plan – Under the provisions of small group reform one standard benefit plan and at least one basic health benefit plan must be made available on a guaranteed

issue basis by all insurers writing small group insurance. The basic benefit plan approach was substantially modified from current administrative rules to allow, again, for the development of lower cost options.

Insurers may offer more than one basic plan, which is any plan with a lower level of benefits than the standard plan.

Financial criteria -- the insurer may offer various levels of deductibles, copayment and other cost sharing arrangements.

Benefits -- the basic benefit plans must contain at least the uniform plan benefits plus the mandated mental health/chemical dependency mandate plus the conversion mandate. Insurers can then add other benefits over and above these specific services and articles (such as medical supplies and equipment) as are requested by the marketplace, designing products to fit what the marketplace can afford.

Standard Health Benefit Plan -- All insurers writing coverage in the small group marketplace must provide, on a guaranteed issue basis, a standard plan which provides a greater level of benefits than basic plans.

Financial criteria -- at least 75% of the covered expenses of the standard plan must be paid after a maximum deductible of \$500 per person or \$1,000 per family. Annual out of pocket expenses cannot be more than \$2,000 per person or \$4,000 for a family with not less than \$1,000,000 lifetime benefit under the standard plan.

Benefits -- the standard plan must include all of the benefits in the uniform plan plus the required benefits of the basic plan plus all other state mandates. Additional services and articles may be covered.

Both the basic and standard benefit modifications are contained in the amendments to HB 466.

Next, I would like to address what the five sets of amendments accomplish.

Amendments Overview

The amendments to HB466:

1. Redefine the basic and standard health benefit plans, both as they were set forth under the Insurance Commissioner's administrative rules and as proposed in the introduced HB466. These are the two types of guaranteed issue plans which will be offered in the small group marketplace. Definitions have been added to simplify the method whereby an HMO certifies that its plans are basic and standard. Clarification of the mandate waiver in 33-22-1821 is made as to which mandated benefits apply to which plans.
2. All language laying out a single guaranteed issue Uniform Plan and the Alternate Contingency language has been removed.
3. The reinsurance program has been rewritten to assure spreading the cost of guaranteed issue beyond the small group marketplace. The changes clearly address concerns that the cost of this reform could be borne solely on the backs of small business. At the beginning of each year the reinsurance board is to project the cost of the potential claims to the reinsurance pool. Fifty percent of that cost is to be built into the cost of the reinsurance premium paid by the small employer insurer buying the reinsurance. The other fifty percent will be paid through a premium all health insurers, health service corporations, HMOs excess and reinsurers pay based on their Montana business in the previous year.
4. Some associations provide health benefit plans to their employer members. Many association members are small employers. Association benefit compliance with the guaranteed issue requirement is clarified to fit with the same number of eligible employees as does small group reform.
5. One amendment allows insurers who were in the market prior to small group reform and who do not wish to now write new small group business to continue servicing existing clients from three to seven years. They must, however, comply with small group reform requirements for those clients. They also cannot write new groups, nor can they rewrite existing groups on new policies.
6. One amendment clarifies that employees who pay the full cost of their individual coverage through a flex benefit plan mechanism are not subject to small group reform.

House Bill 446 -- preexisting condition reform

1. Lowers the number of years an insurer can look back to determine preexisting conditions. Current law allows five. The change will now allow for only a three-year look back.

2. Clarification is made for disability income insurance to allow for conditions manifesting themselves during the first twelve months of coverage.
3. Clarifies the use of elimination riders, a mechanism whereby insurers can cover a person with a specific health condition which normally would preclude that person from getting insurance. The insurer riders out that condition, and accepts the individual for all other health conditions or incidental injuries. This has been standard practice in the marketplace, but only recently the Insurance Department said the practice was not allowed. Therefore, this amendment clarifies what has been standard practice.
4. Retroactive applicability -- important because riders have not previously been specifically addressed in Montana law, but have been an industry practice not precluded by Montana law for a number of years.

House Bill 531 -- Medisaves, Basic Plan Design, information, etc.

The amendments to this bill remove all sections but the information reporting requirements on health care facilities and providers. All other provisions are addressed in other bills, with the exception of Section 6 -- standardized claim form. That provision has been addressed for insurers through administrative rule by the Insurance Commissioner. The Health Care Advisory which is being created by HB511 should continue to pursue this for other payors, where it has jurisdiction.

House Bill 533 -- health benefit plan revision, preexisting waiver portability

1. In addition to the individual market reforms contained in this bill, insurers and HMOs will now be required to meet certain insurance product disclosure standards for prospective applicants. These standards will allow comparison of benefits, financial requirements like deductibles, potential price and underwriting characteristics, and general premium trend information. (Amendment 3, New Sections 5-7)
2. The Uniform Benefit Plan which all insurers will be required to make available to individuals and groups on an underwritten basis is defined in Amendment 3, New Sections 8-10.
3. Conversion -- for the past 14 years, individuals who leave a group insurance plan have had the right to convert to individual coverage on a guaranteed issue basis without preexisting condition applicability. The conversion right has now been expanded to include conversion to the lowest cost Basic Plan at 150% of the highest rate for that plan.

Senate Bill 341 -- Montana Comprehensive Health Association

The MCHA board had recommended some statutory changes to the current benefit plan, and has also expanded benefits where they have been able to do so. The amendments:

1. Enhance current MCHA benefits by adding coverage for listed transplants and several other services.
2. Give the board flexibility to provide more than one level of benefits, so long as it continues to offer the current \$1,000 deductible, 80/20 plan with an expanded lifetime maximum of \$500,000.

I can tell you from first-hand experience that this has been a grueling, time-consuming, high intensity level process by which we have reached consensus on each of these issues.

Each party has had to give considerable ground from their original positions on any number of issues.

I believe the people of Montana have been well served by the process. We have made substantial improvements in the small group insurance market as well as expanding reforms in the individual market and insurance industry as a whole.

Now that we have dealt significantly with insurance issues, I hope when you return in 1997 we can focus as much time and energy on cost issues which will continue to be at the forefront of health care and our ability to purchase insurance and health care services.

BENEFIT DESIGN

Uniform:

Group and Individual
Nonguaranteed Issue

Financial Criteria:

- (a) Pay 50% of the covered expenses in excess of an annual deductible that does not exceed \$1,000 per person or \$2,000 per family;
- (b) Include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and
- (c) Be subject to a maximum lifetime benefit of \$1,000,000.

Benefit Criteria:

Covered expenses must include the following medically necessary services and articles when prescribed by a physician or other health care provider as designated in the contract:

- (a) hospital services;
- (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;
- (c) use of radium or other radioactive materials;
- (d) oxygen;
- (e) anesthetics;
- (f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3) (c) (i);
- (g) services of a physical therapist;
- (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;
- (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;
- (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50 percent, up to a maximum of \$1,000;
- (k) prosthetics, other than dental;
- (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- (m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration at the rate of 50 percent, up to an annual maximum of \$1,000.
- (n) medically necessary, nonexperimental organ transplants of the following major organs, limited to a maximum of \$150,000 in a lifetime, with an additional \$10,000 to be paid for costs associated with the donor:
 - 1. kidney
 - 2. pancreas
 - 3. heart
 - 4. heart/lung
 - 5. lung

- 6. liver
- 7. high-dosage chemotherapy/bone marrow transplantation
- 8. cornea
- (o) pregnancy, including complications of pregnancy;
- (p) newborn infant coverage as provided in 33-22-301, 33-22-504, and 33-30-1001, MCA;
- (q) sterilization;
- (r) immunizations;
- (s) outpatient rehabilitation therapy;
- (t) foot care for diabetics;
- (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
- (v) travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

BASIC

Small Group and lowest cost for conversion
Guaranteed Issue

Financial Criteria:

Lower than standard, determined by marketplace

Benefit Criteria:

Uniform Benefit Plan

Mental Health/Chemical Dependency

Conversion

Plus whatever else marketplace determines up to standard

STANDARD

Small Group
Guaranteed Issue

Financial Criteria:

- (a) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed \$500 per person or \$1,000 per family.
- (b) The coverage must include a limitation of \$2,000 per person or \$4,000 per family on the total annual out-of-pocket expenses for services covered.
- (c) The coverage may be subject to a maximum lifetime benefit, but such maximums, if any, must not be less than \$1,000,000.

Benefit Criteria:

Uniform Benefit Plan

Plus all state mandates

Plus any additional benefits an insurer may decide to offer

MONTANA COMPREHENSIVE HEALTH ASSOCIATION

State-Sponsored High-Risk Pool for Individuals
Guaranteed Issue

Financial Criteria:

- (a) Pay at least 50% of covered expenses in excess of an annual deductible with \$1,000 annual deductible.
- (b) Limitation of \$5,000 annual out-of-pocket expenses for services covered.
- (c) Maximum lifetime benefits of at least \$100,000--the current level is \$350,000.
- (d) One option must be offered with coverage for 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed \$1,000 per person. This association plan must provide a maximum lifetime benefit of \$500,000.

Benefit Criteria:

New benefits added to those already in plan are:

- a) Drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration, covered at 50% of the expense up to an annual maximum of \$1,000;
- b) Medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lung, liver, cornea, and high-dosage chemotherapy/bone marrow transplantation, limited to a lifetime maximum of \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with the donor;
- c) Pregnancy, including complications of pregnancy;
- d) Newborn infant coverage, as required by 33-22-301;
- e) Sterilization;
- f) Immunizations;
- g) Outpatient rehabilitation therapy;
- h) Foot care for diabetics;
- i) Services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
- j) Travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

Amendments to House Bill No. 533
Third Reading Copy

Requested by Senator Steve Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"
2. Page 1, line 20.
Strike: "TYPE OF"
3. Page 1, line 23.
Strike: "OR"
Following: "ORGANIZATION"
Insert: ", or a fraternal benefit society"
4. Page 1, line 26.
Following: "issued"
Strike: "or delivered for issue"
Insert: "for delivery"
5. Page 1, lines 27 and 28
Strike: lines 27 through "individuals" on line 28
6. Page 1, line 29.
Following: "self-" in two places
Strike: "insured"
Insert: "funded"
7. Page 2, line 8.
Following: "FOR"
Strike: the remainder of line 8 through "year"
8. Page 2, lines 11 and 12.
Following: "FOR"
Strike: the remainder of line 11 through "year" on line 12
9. Page 2, line 22.
Strike: "a group or"
Insert: "an"
10. Page 2, line 24.
Following: "charges for"
Insert: "individual"
11. Page 2, line 27.
Following: "BUSINESS"

Insert: "as defined in [section 1]"

12. Page 3, line 8.

Following: "means a"

Strike: the remainder of line 8

Insert: "disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society."

13. Page 3, line 9.

Insert: "(3) The provisions of Title 33, chapter 1, parts 3 and 7 apply to this section."

14. Page 3, lines 29 and 30.

Strike: "1"

Insert: "2"

3-16-95

Amendments to House Bill No. 533
Third Reading Copy

Requested by Senator Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, line 11.

Following: "INSURER;"

Insert: "REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR
BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM
HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN
CONVERSION POLICIES;"

2. Title, line 11.

Strike: "SECTION"

Insert: "SECTIONS"

3. Title, line 12.

Following: "33-22-101,"

Insert: "33-22-508, AND 33-30-1007,"

4. Page 3, line 25.

Insert: "

NEW SECTION. Section 5. Disclosure standards -- individual policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. Section 6. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. Section 7. Disclosure standards -- health maintenance organizations. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and

coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate health benefit plan.

(4) An insurer or producer shall provide an outline of coverage to any individual upon request.

NEW SECTION. Section 8. Uniform health benefit plan -- individual. (1) Each insurer or health service corporation delivering or issuing for a delivery in this state an individual disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed \$1,000 per person or \$2,000 per family;

(c) include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of \$1 million.

NEW SECTION. Section 9. Uniform health benefit plan -- group. (1) Each insurer or health service corporation delivering or issuing for a delivery in this state a group disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed \$1,000 per person or \$2,000 per family;

(c) include a limitation of \$5,000 per person or \$7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of \$1 million.

NEW SECTION. Section 10. Uniform health benefit plan -- health maintenance organization. Each health maintenance organization delivering or issuing for a delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan providing benefit equivalency and benefit value, as defined in chapter 22, part 18, comparable to the uniform health benefit plan required in [section 8(2)].

Section 11. Section 33-22-508, MCA, is amended to read:

"33-22-508. Conversion on termination of eligibility. (1) A group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, his a person's dependents, or family members covered under the policy ceases because of termination of his the person's employment or of his the person's membership in the class or classes eligible for coverage under the policy or as a result of his a person's employer discontinuing his the employer's business or as a result of his a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and he the person is not insured under another major medical disability insurance policy or plan, he the person is entitled to have issued to him the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on himself the person, his the person's dependents, or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer must make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer must make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan under 33-22-1803(5). If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

{Internal References to 33-22-508:

2-18-704x

33-22-1113x

33-22-513x

33-22-513x}

Section 12. Section 33-30-1007, MCA, is amended to read:

"33-30-1007. Conversion on termination of eligibility. (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, his a person's dependents, or family members covered under the policy ceases because of termination of his the person's employment or of his a person's membership in the class or classes eligible for coverage under the policy, as a result of an employer discontinuing his the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, such a person shall, provided he the person has been insured for a period of 3 months and that he the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to him the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on himself the person, his the person's dependents, or family members, provided application for the individual policy shall must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy shall must be at the insurer's then customary rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation must make an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan under 33-22-1803(5). If the insurer is not a small employer carrier under chapter 22, part 18, the insurer must make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

{Internal References to 33-30-1007:

33-30-1015x 33-30-1015x 33-30-307x}

5. Page 4, line 1.

Insert: "(3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8].

(4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

(5) [Sections 7 and 10] are intended to be codified as an integral part of Title 33, chapter 31, part 3, and the provisions of Title 33, chapter 31, part 3, apply to [sections 7 and 10]."